UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

STATE OF WASHINGTON, et al., Plaintiffs, v. DONALD J. TRUMP, in his official capacity as President of the United States of America, et al., Defendants.	NO. DECLARATION OF CRYSTAL BEAL, MD

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I, Crystal Beal, declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my personal knowledge.

2. I am a Board-Certified Family Medicine physician and the founder of a telemedicine-based gender-affirming clinic. I am a licensed physician in Oregon, Montana, California, Wyoming, Washington, and Alaska. Additionally, I have a telehealth license in Florida. I am board-certified by the American Board of Family Medicine. I am a current member of the American Board of Family Medicine, the World Professional Association for Transgender Health (WPATH), and GLMA (Health Professionals Advancing LGBTQ+ Equality).

3. I am an instructor with the University of Washington School of Medicine and School of Public Health. I have completed the Physicians for Reproductive Health's Leadership Training Academy. I am currently involved with the Western Washington Pediatric and Adolescent Gender Care Network as well as additional anonymous care and advocacy organizations. I have completed over 350 hours of continuing medical education on the topic of transgender health care. I have also conducted trainings for Seattle Children's Gender Clinic, American Academy of Family Practice, WPATH, Pacific Lutheran University, Florida State University College of Medicine, and the University of Washington School of Medicine, amongst others. I am a nationally known educator in the field of gender-affirming care.

4. I specialize in providing gender-affirming medical care for transgender and gender diverse adolescents and adults. In my practice, I follow evidenced-based national standards to provide medical care for transgender adolescents. Per standards of care, medical interventions are not available until youth are actively in puberty; as such, medical interventions are not provided to children.

5. Gender-affirming care is not new. The first gender-affirming clinic in the Western World opened in 1919. Over 2000 peer-reviewed publications since 1975 have established the safety and efficacy of gender-affirming care. Every major medical association in the United

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States supports medical care for transgender people. Despite the current political climate, the medicine and scientific evidence are not up for debate.

6. Studies of tens of thousands of transgender and gender diverse youth show that receipt of gender-affirming medical care, including puberty blockers and gender-affirming hormones, is associated with fewer symptoms of depression, anxiety, and reduces the likelihood of suicidal ideation by 73%. In fact, multiple longitudinal studies show that transgender youth who receive this care report improved mental health, life satisfaction, and quality of life.[1]

7. The research is also clear that transgender young people grow into transgender adults. In a recent study, 98% of transgender adolescents who received this care continued treatment into adulthood. Small studies claiming that children will "change their mind" are simply false. These small studies are over 10 years old, use an outdated version of diagnostic criteria, and only included a total of less than 260 youth. Most of the youth in those studies were likely misdiagnosed using previous less rigorous criteria and would not meet our current diagnostic criteria for gender dysphoria.[2]

8. 29 major medical associations have policy statements indicating the medical necessity of gender-affirming care. [3] These 29 associations are well-respected organizations with

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[1] *See, e.g.*, Rew, L., Young, C.C., Monge, M. and Bogucka, R. (2021), *Review: Puberty blockers for transgender and gender diverse youth—a critical review of the literature*, Child Adolesc Ment Health, 26: 3-14. https://doi.org/10.1111/camh.12437; Turban, J. (2022 January 24), *The Evidence for Trans Youth Gender-Affirming Medical Care. Psychology Today*, https://www.psychologytoday.com/us/blog/political-minds/202201/the-evidence-trans-youth-gender-affirming-medical-care; de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT, *Young adult psychological outcome after puberty suppression and gender reassignment*, Pediatrics, 2014 Oct; 134(4):696-704. doi: 10.1542/peds.2013-2958. Epub 2014 Sep 8. PMID: 25201798. *See also*, *Citations Supporting Adolescent Gender Care - April 2024*, https://queerdoc.com/citations-supporting-adolescent-gender-care/ (last accessed Feb. 2025).

[2] *See, e.g.*, Wojniusz S, Callens N, Sütterlin S, et al., *Cognitive, emotional, and psychosocial functioning of girls treated with pharmacological puberty blockage for idiopathic central precocious puberty*, Front Psychol. 2016, 7: 1053; Steensma TD, McGuire JK, Kreukels BP, Beekman AJ, Cohen-Kettenis PT, *Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study*, J Am Acad Child Adolesc Psychiatry, 2013 Jun; 52(6):582-90. doi: 10.1016/j.jaac.2013.03.016. Epub 2013 May 3. PMID: 23702447; Drummond, Kelley & Bradley, Susan & Peterson-Badali, Michele & Zucker, Kenneth, *A Follow-Up Study of Girls With Gender Identity Disorder, Developmental psychology*, (2008), 44. 34-45. 10.1037/0012-1649.44.1.34; Wallien MS, Cohen-Kettenis PT, *Psychosexual outcome of gender-dysphoric children*, J Am Acad Child Adolesc Psychiatry. 2008 Dec; 47(12):1413-23. doi: 10.1097/CHI.0b013e31818956b9. PMID: 18981931.

[3] These organizations include, but are not limited to, the: American College of Physicians (Founded: January 8, 1915, Number of members: 160,000); American Medical Association (Founded: May 7, 1847; Number of members: 240,359 as of 2016); American Osteopathic Association (Founded: April 19, 1897; Number of members: more than 168,000); American Psychiatric Association (Founded: October 16, 1844; Number of

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long histories and prolific memberships of over 700,000 clinicians. They have published evidence-based guidelines in other areas of adolescent care that constitute national standards, such as the Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents or Management of Newly Diagnosed Type 2 Diabetes Mellitus (T2DM) in Children and Adolescents. The medical organizations opposing gender-affirming care are small organizations with limited membership of less than 6,000 clinicians. They have no publications that are widely read, nor treatment guidelines that have been adopted as national standards of care.

9. When a patient presents with gender dysphoria, it means they experience distress related to their gender that limits their ability to function. When appropriate for that individual patient, medical intervention in the form of gender-affirming care alleviates that distress and improves overall health and wellness including mental health and functional status.

10. I determine what type of medical care, if any, is appropriate for each patient on an individual basis. With adolescent patients, I typically see a patient multiple times before I make any medical diagnosis, recommendations, or prescribing. During our first visit, I meet with an adolescent and their parents or guardians to become familiar with their entire medical history. I ask questions to learn about their experience of their gender throughout their lifetime. I ask questions to understand what, if anything, about their body causes them distress. I ask questions to understand their goals for their body as they grow up. I ask about all their known diagnosed health conditions. I run blood tests, if appropriate. I ask questions to understand if their body is experiencing puberty, and at what stage. I screen for any intersex conditions. I screen for anxiety, depression, attention deficit disorder, autism spectrum disorder, and eating disorders. I ask

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members: 37,400); American Academy of Pediatrics (Founded: 1930; Number of members: 67,000); The Endocrine Society (Founded: 1916; Number of members: over 18,000); The Pediatric Endocrine Society (Founded: 1972; Number of members: 1,500); American Public Health Association (Founded: 1872; Number of members: 25,000); American Academy of Child and Adolescent Psychiatry (Founded: 1953; Number of members: more than 10,000); American Academy of Family Physicians (Founded: 1947; Number of members: 127,600); American Academy of Pediatrics (Founded: 1930; Number of members: 67,000); American College of Obstetricians and Gynecologists (Founded: 1951; Number of members: 60,0000).

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questions to understand the adolescent's family and family dynamics. I ask questions to understand if the adolescent is appropriate and ready for a medical intervention, and similarly, if their family is ready.

11. At a follow up appointment, I discuss with the adolescent and their parents or guardians all possible treatment options to treat a diagnosis of gender dysphoria, if the diagnosis is appropriate. The adolescent has many different options, including non-treatment. Possible reasons for non-treatment are reviewed. If a patient and family desires non-treatment, work with a supportive mental health provider and family counseling is recommended. The adolescent and family may choose not to engage in any medical treatment, and instead proceed with non-treatment, and/or social or legal support to affirm the adolescents' gender identity. Social support looks different for everyone, but it can include using different name or pronouns, using or not using makeup, wearing different clothing, using a binder to reduce the appearance of breasts, and using tucking underwear to reduce the appearance of genitalia. If an adolescent and family choose medical treatment, depending on the adolescent's individual needs, I may prescribe puberty blockers, hormone replacement therapy, period blocking medication such as oral contraceptives, progesterone shots or pills, medications to slow hair loss or help facial hair grow, procedural hair removal, or to pursue gender-affirming surgery when age-appropriate.

12. After I prescribe an adolescent patient medication, I schedule a preliminary follow-up appointment in 4-6 weeks to assess their treatment, then again in 6-8 weeks after that. Ongoing care typically includes visits every 3 months after that for adolescent patients and their families. I typically ask my adolescent patients to see me for follow-up care every 3 months so that I can properly assess and support their care.

13. Over the course of 8 years as a physician in transgender medicine practice, treating hundreds of transgender and gender diverse adolescents, I have seen firsthand the medical necessity of gender-affirming care. I have had parents of transgender youth tell me that after their kid received gender-affirming care, they saw their child blossom—that they finally

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got to know their child and see their personality shine through. One of my earliest patients was unable to sit onscreen without hiding behind their hair when we met. Now with access to appropriate medicine they sit center screen, smiling, with their hair out of their face. They even participated in a school drama activity this past year. I routinely watch my adolescent patients become more comfortable, confident, and joyful as they begin to receive gender-affirming care. I have had patients tell me they felt like their world was in scales of gray until they started gender-affirming care, and now they see their world in color. I have had patients tell me they are alive because of the gender-affirming care provided. I have watched dozens of adolescents grow into the adults they want and need to be, able to attend college and get jobs because their dysphoria is well-managed.

14. I understand that the President of the United States has issued an Executive Order (EO) that would severely limit care for transgender and gender diverse youth across the country and that would seek to prosecute providers of such care. The directives of the EO would force me to choose between fulfilling my oath and duty as a physician, or to act against the principles of medical ethics by denying my patients lifesaving, medically necessary, evidence-based health care. The EO is in direct opposition to the current evidence-based medical practices.

15. The EO makes many false statements and claims in direct opposition to the growing body of medical literature and over 100 years of medical practice. Such examples of these false statements include but are not limited: to the EO's statement of regret rates which are 2% or less in the field of transgender medicine (whereas they can exceed 30% in the field of orthopedics), the EO's determination of WPATH as junk science lacking scientific integrity (WPATH was founded over 40 years ago with the most current standards developed by over 50 global experts in the field with over 1500 references cited), and the EO's reference to rapid-onset gender dysphoria which is not recognized as a diagnosis and the paper introducing it was retracted due to failure to comply with the ethical board.

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16. The policies in this EO will cause the genocide of a generation of transgender youth. This EO constitutes a hate crime. It is based in discrimination not science. Recent studies show that suicidality among transgender people increases after states implement bans of gender-affirming care.[4] Simply put, implementation of this EO will mean fewer transgender and gender diverse youth will live to adulthood. Providers will have to choose between providing evidence-based, life-saving medical care or risking their careers, livelihoods, and possibly criminal charges. I know of colleagues who have left individual states and the country because of the moral injury caused by care bans. All Americans will suffer due to the loss of physicians created by this EO.

I declare under penalty of perjury under the laws of the State of Washington and the United States of America that the foregoing is true and correct.

DATED this Fouth day of February 2025 at Seattle, Washington.

Crystal Beal, MD

[4] Lee, W.Y., Hobbs, J.N., Hobaica, S. et al., State-level anti-transgender laws increase past-year suicide attempts among transgender and non-binary young people in the USA, Nat Hum Behav 8, 2096–2106 (2024), https://doi.org/10.1038/s41562-024-01979-5.

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